

CLIENT AND ESCORT TRAVEL

Client's Name: _____ Soc. Sec. # _____

Client's Address: _____

Escort's Name: _____ Soc. Sec. # _____
(Must have legal custody)

Escort's address: _____
City, State Zip Code

Referring Counselor's Name & Program Affiliation: _____

Treatment Program (based on IHS List)? _____

Treatment Center's Address? _____

Number of Treatment Days Requested (45 Days for Non-IHS facilities)? _____ days.

Admission Date ____/____/____ Tentative Discharge Date* ____/____/____

***Note:** Planned discharge date is the number of treatment days plus one day. Do not have planned discharged date computed on a Sat. or Sun. The number of treatment days may be less than the usual program treatment schedule.

Mode of Transportation: ☐ POV ☐ GSA/Tribal ☐ Air (Commercial Carrier)

Escort/Client Departure Date _____

Escort Return Date _____ Approx. Time _____ ☐am ☐pm

Client Return Date _____ Approx. Time _____ ☐ am ☐ pm

Travel Route (Example: How will client and escort get to and from airport; how will they get to treatment center)

POV – Total Mileage (Roundtrip): _____

Special Instructions: _____

